not be limited to the governing body. There are multiple avenues for participation: serving on sub-area advisory councils, task forces and committees, or attending meetings as observers. This allows physicians to become part of the decision-making process that could finally achieve a mutually agreeable solution.

The recommendations of health planning agencies can have a significant impact on health care services in many communities. At present the HSA's monitor and regulate all major expansion programs within the health care system so that costly duplication of services can be avoided while necessary services are maintained. Eventually they will assume responsibility for reviewing the appropriateness of existing health care services for their respective areas.

Local HSA's respond to local conditions and at present are controlled by the local community. Physicians have an enormous stake in seeing that they succeed because, as Dr. John Freymann—the President of the National Fund for Medical Education and himself a physician—has noted, providers have the most to lose if these local agencies fail.[1] The alternative to provider inertia and local agency failure would be monolithic control of the entire health care system from Washington.

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Psychogenic Rheumatism

TO THE EDITOR: Dr. Michael Reynolds' excellent article on psychogenic rheumatism in the April issue again reminds us that musculoskeletal symptoms can be a somatic expression of emotional problems.

However, I would disagree with his statement that the distinction of psychogenic from organic disease "should not be difficult." The concept that many of these symptoms "fail to correspond to patterns of organic disorders" implies that the patterns of organic disorder are all clearly and completely understood at this time. I do not feel that this is an accurate conclusion. I agree with Dr. Reynolds that the diagnosis of rheumatoid arthritis and its variants is often used indiscriminantly, yet am concerned that the concept of psychogenic rheumatism may not also become overused and abused. It is soothing, unfortunately, to physicians to label illnesses as idiopathic or functional rather than to admit the limitation of current diagnostic methods. This is dangerous, not only because of the social implications for the patient, but also because it tends to decrease a doctor's diagnostic alertness to newer patterns of organic disorder and to those that await discovery. This was well expressed by Jean Marie Charcot (1825-1893) who said "In the last analysis, we see only what we have been taught to see. We eliminate and ignore everything that is not part of our prejudice."

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Of Pediatrics and Geriatrics

TO THE EDITOR: Dr. Alex Comfort's commentary "Geriatrics—The Missing Discipline?" (West J Med 128:257-259, Mar 1978) and his numerous contributions in similar vein, prompt me to put on paper thoughts I have had for some time now.

I agree that medicine (and surgery) of the aged is different than for adults, just as pediatrics is different. Indeed pediatrics is more related to geriatrics (and vice versa) than either is to adult medicine. As far as these two specialties go, it is true that certain diseases are more or less confined to one or other extreme of life. But there are many that afflict both age groups in similar manner. Examples are pneumonia, electrolyte disturbances, metabolic diseases and acute conditions of the abdomen, to name a few. Furthermore, there is no reason why one medical specialist could not become expert at those conditions which are common to both groups, as well as congenital and degenerative diseases which afflict pediatric and geriatric patients respectively.

The presentation of major disorders becomes increasingly nonspecific at both extremes of age. Furthermore, in childhood as well as in old age, most people are "well" despite minor continuing conditions; as Hodkinson, quoted by Comfort, says, a common syndrome in the elderly, is the equivalent of "failure to thrive" in pediatrics.

Another great similarity between the two disciplines is the dose range of, and the response to, commonly used medications as well as the complications of these medications.

With the dwindling of the pediatric population and the parri pasu increment in the ranks of the elderly, a marriage between the two disciplines

would also have logistic merit. A number of pediatricians have deserted the ranks to become family physicians; an organized flow into the combined specialty of pediatrics and geriatrics would appear to be a natural solution to this problem in the short run. In the longer view, a combined pediatric-geriatric residency could produce physicians well-rounded in both these fields.

There could be some objection raised to housing the patients in the two extremes in the same unit within a hospital, but this need not apply. Similarly there may be objection to having these patients in the same waiting room in the doctor's office, but this too could be avoided or lessened by having separate waiting areas.

I offer this suggestion to the pediatricians of this country not at all in jest; they have a golden opportunity to salvage their profession and indeed to enhance it by taking on the challenge of the medical care of the elderly who now, as Dr. Comfort points out, are the pariahs of medicine and of society in general.

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Lincoln's Health—Dr. Schwartz Responds

TO THE EDITOR: My recent article, Abraham Lincoln and Cardiac Decompensation (West J Med 128:174-177, Feb 1978) concerned itself only with heart failure, the evidence for the related diagnoses of the Marfan syndrome and aortic insufficiency having been reported years ago.[1,2] In spite of this, Dr. Walter T. Flaherty of Tustin, California cites the latest report in rejecting the diagnosis of the Marfan syndrome while strangely accepting the diagnosis of aortic insufficiency (Correspondence, West J Med 128:352-353, Apr 1978). Actually, the diagnosis of a valvular lesion is untenable in Mr. Lincoln unless he did indeed have the Marfan syndrome—his "Wasserman" was negative.[3]

Regardless, Flaherty's refutation of the Marfan diagnosis is based extensively on the statuary of Lincoln—these disclosing, he states, no eye or skeletal deformities. I offer in this regard a quote from a classic study: "There are sculptors of the very highest rank who have declared . . . that . . . Lincoln is not a proper theme for sculptoral treatment . . . the unique problem . . . [is] . . . representing Lincoln's lank awkward figure . . . in a . . . work of art."[4] Despite this, many sculptors have made the attempt, some even portraying him as an Adonis, while Vinnie Ream—the sculptor Flaherty extols—depicted the President in a Roman toga. Other scuptors met the problem; Barnard's statue intended for London caused an international furor with its realism—the large hands, the big feet, the awkward pose—which found warm acceptance by an English consultant, George Bernard Shaw.

As to the casts of Lincoln's hands negating the diagnosis, a careful review of the original genetic-morphologic report[1] will show that the casts were specifically and most objectively considered by referring to an earlier, independent, anthropometric analysis of the hands by their custodian at the Smithsonian Institute. The data were found analogous to and consistent with an abnormal metacarpal index as calculated in the Marfan syndrome from an x-ray study of the hand, this retrospective "reconstructed x-ray" for Mr. Lincoln, as well as the Marfan diagnosis, being accepted editorially in 1964 by the *British Medical Journal*.[5] Contrary to Flaherty's opinion, one can readily find reference to bony deformities of Lincoln's chest—his law partner clearly described it as a "sunken breast,"[1] that is, a pectus excavatum. Also, Lincoln did discuss his eye problems, both with his secretary John Hay and with a reporter, Noah Brooks, and revealed to them his two curious episodes of diplopia. Finally, hypertropia of the left eye was described by the President's contemporaries and is apparent in his photographs, if not in the more flattering statuary.

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